DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)

PLANNED ACTION NOTICE
MINI-ASSESSMENT

CLIENT/APPLICANT NAME AND ADDRESS

REPRESENTATIVE NAME AND ADDRESS

Your DDD Mini-Assessment was completed on _____

RESULT

Your Mini-Assessment assigned you to the following group:

- ☐ High Level of Need
- ☐ Moderate Level of Need
- ☐ Low Level of Need

WHAT HAPPENS NEXT?

Your Case/Resource Manager will:

- ☐ Refer you for a full assessment.
- ☐ Refer you to the full Assessment Referral Database.
- ☐ Refer you for further review because of identified
  - ☐ Community protection needs.
  - ☐ Risk of placement into a more restrictive setting.
- ☐ Offer you information and referral services.

YOUR APPEAL RIGHTS

You have ninety (90) days from the receipt of this notice to appeal this decision.

- Per WAC 388-824-0320 you have the right to appeal if you disagree with information entered into the Mini-Assessment or if DDD denies your request for a reassessment.
- You do not have appeal rights to the algorithm that determines your level of need.

DO YOU HAVE QUESTIONS?

If your needs change or you have questions about your Mini-Assessment or appeal rights, contact

_____ at _____

CASE/RESOURCE MANAGER | TELEPHONE NUMBER

Washington State Department of Social & Health Services
DDD Division of Developmental Disabilities

PLANNED ACTION NOTICE
DDD MINI-ASSESSMENT
REQUEST FOR HEARING

per Chapter 388-02 for DSHS hearing rules.

FOR AGENCY USE ONLY

☐ **Oral request taken by:**

NAME | TELEPHONE NUMBER

INVOLVED DIVISION/ORGANIZATION

MAIL TO: OFFICE OF ADMINISTRATIVE HEARING (OAH), MAIL STOP: 42489
PO BOX 42489
OLYMPIA WA 98504-2489

FAX: 360-586-6563

I request a hearing because I disagree with the following level of need result by the Division of Developmental Disabilities (DDD):

YOUR NAME (PLEASE PRINT)	DATE OF BIRTH	SOCIAL SECURITY NUMBER
ADDRESS OF PERSON REQUESTING HEARING	CLIENT ID NUMBER	
CITY STATE ZIP CODE	TELEPHONE NUMBER (INCLUDE AREA CODE) ☐ **MESSAGE PHONE**	

I was notified of the decision on: _____ by: _____
DATE DSHS OFFICE NAME AND LOCATION

I want continued assistance, if I am eligible: ☐ **Yes** ☐ **No** Program: _____

I am represented by (if you are going to represent yourself, do not fill in the next two lines):

YOUR REPRESENTATIVE'S NAME	ORGANIZATION	TELEPHONE NUMBER
ADDRESS	CITY	STATE ZIP CODE

☐ **I authorize release of information about my hearing to my representative.**

YOUR SIGNATURE	DATE

Do you need an interpreter or other assistance or accommodation for the hearing? ☐ **Yes** ☐ **No**

If yes, what language or what assistance? _____

Administrative Law Judges (ALJ's) may hold some hearings by telephone. If you want to change to an in-person hearing, follow the instructions in the Notice of Hearing that will be mailed to you by OAH.